FOR OFFICIAL USE ONLY
INTAKE STAFF: _____
ACTS # _____

Comprehensive & Extended Care Facilities
Self-Report Form

Today's Date	**Time**	**Provider Name**	**Provider #**
Mailing Address		**City**	**State**	**Zip**
Telephone	**Extension**	**Fax**	**E-Mail**
Person completing report:			**Direct Number**
Title or Relationship to Resident:			
Name of resident(s) involved			
Type of Report	☐ Abuse	☐ Neglect	☐ Injury of unknown origin	☐ Misappropriation of resident property
Date/Time Of Incident	**Location of Incident**	**Witness(s)**	
Status of Resident	**Alleged Perpetrator(s)** *(if applicable, provide license #)*		
Local Law Enforcement Contacted? ☐Yes ☐No	*If yes,* **Date & Time**	**Case Number**	**Officer's Name**

Highlight space to enter comments

Events Of Incident(S)

Highlight space to enter comments

Measures taken to prevent further incidents of similar nature

Highlight space to enter comments

Results of investigation

Forward first report within 2 hours if serious bodily harm resulted, all others within 24 hours,
Forward investigation results within 5 days
To Fax: 410.402.8113 or email to: nhselfreport@dhmh.state.md.us